



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Doctor's Hospital at Renaissance

Respondent Name

City of McAllen

MFDR Tracking Number

M4-17-2052-01

Carrier's Austin Representative

Box Number 21

MFDR Date Received

March 6, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare specific amount."

Amount in Dispute: \$267.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent reimbursed the facility for CPT code 27792 in accordance with the 200% calculation as mandated. No additional reimbursement is due."

Response Submitted by: Thornton Biechlin Reynolds & Guerra

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 3, 2016	73610, 51798	\$267.28	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital fee guidelines.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - P14 – Additional payment made on appeal/reconsideration
 - PN – The service is considered incidental, packaged, or bundled into another service or APC payment

Issues

1. What rule applies to reimbursement?
2. Is the carrier's denial supported?

Findings

1. The requester seeks additional reimbursement of \$267.28 for codes 73610 – "X-ray exam of ankle", and 51798 – "Urine capacity measure" rendered on August 3, 2016.

The carrier denied the disputed services as 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" and PN – "The service is considered incidental, packaged, or bundled into another service or APC payment."

28 Texas Administrative Code §134.403 Hospital Facility Fee Guideline—Outpatient, states in relevant portions:

(b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise

(3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

(f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

The application of the above is discussed below.

2. The Medicare payment policies used to calculate the MAR are found at, www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

The resources that define the components used to calculate the Medicare payment for OPPS are found below:

- **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
 - To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.
- **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at

the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPTS Addenda, Addendum, D1.

- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPTS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

The submitted medical claim contains Code 27792 – “Treatment of ankle fracture.” The status indicator assigned to this code is “J1 – Hospital Part B services paid through a comprehensive APC.”

The Medicare payment policy found at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf> states, “Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.” “The following services are excluded from comprehensive APC packaging: brachytherapy sources (status indicator U), pass-through drugs, biologicals and devices (status indicators G or H), corneal tissue, CRNA services, and Hepatitis B vaccinations (status indicator F), influenza and pneumococcal pneumonia vaccine services (status indicator L), ambulance services, mammography, certain preventive services.”

As the disputed services are not excluded from the applicable Medicare payment policy or comprehensive APC, the carrier’s denial is supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____	_____	March 31, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.